

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

34897  
2296

FILED OCT 23 1948

Registration District No. 2063

Primary Registration District No. 2063

State File No. 2296

Registrar's No. 2296

1. PLACE OF DEATH:

(a) County ST. LOUIS  
(b) City or town CAYTON  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
ST. LOUIS COUNTY HOSPITAL  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 4 DAYS  
(Specify whether  
In this community 25 YEARS  
years, months or days)

3. (a) PRINT FULL NAME MARIEA CROMER

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced WIDOWED  
6. (b) Name of husband or wife WILLIAM 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased 10 2 1853  
(Month) (Day) (Year)

8. AGE: Years 95 Months 0 Days 1 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace FRANKLIN Co. Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation None Housewife

11. Industry or business None

12. Name John Seaton

13. Birthplace Unknown  
(City, town, or county) (State or foreign country)

14. Maiden name Unknown Emmett

15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Corcoran

(b) Address 7424 HAZEL

17. (a) Burial (b) Date thereof 10-5-1948  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Hill Cemetery

18. (a) Signature of funeral director Jay B. Smith

(b) Address 7456 Manchester Rd.

19. (a) 10-3-48 (b) Paula Thompson  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County ST. LOUIS  
(c) City or town MAPLEWOOD  
(If outside city or town limits, write "RURAL")  
(d) Street No. 7424 HAZEL  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCTOBER day 3  
year 1948 hour 9 minute 15 P. M.

21. I hereby certify that I attended the deceased from SEPTEMBER 29, 1948, to OCTOBER 3, 1948,  
that I last saw her alive on OCTOBER 3, 1948,  
and that death occurred on the date and hour stated above.

Immediate cause of death Fracture hip  
Arteriosclerotic Heart disease  
Due to Pneumonia  
Stroke

Due to 1962  
Other conditions 18  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident 126  
(b) Date of occurrence 10-3-48  
(c) Where did injury occur? at home  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work \_\_\_\_\_ (Specify type of place)  
(e) Means of injury Fall

23. Signature John Wm Smith (M. D. or other)  
Address 601 Southwood Blvd. Date signed 10-4-48

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by \_\_\_\_\_

\_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_  
working under my personal supervision.

Signed \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

If this body is not embalmed, fact should be so stated above.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. no  
Registrar's No. 2296

Registration District No. 317

Primary Registration District No. 3063

1. PLACE OF DEATH:

(a) County St Louis  
(b) City or town Clayton  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution (Specify whether  
In this community years, months or days)

3. (a) PRINT FULL NAME Melissa Cramer

3. (b) If veteran, name war 3. (c) Social Security No.

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife 6. (c) Age of husband or wife if alive

7. Birth date of deceased 6 of (Month) 2 (Day) 1995 (Year)

8. AGE: Years 95 Months 9 Days 1 (Less than one day hr. min.)

9. Birthplace (City, town, or county) (State or foreign country) Mo

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County  
(c) City or town (If outside city or town limits, write "RURAL")  
(d) Street No. (If rural, give location)  
(e) Citizen of foreign country? (Yes or No)  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 year 1995 hour 6 minute 13 M.

21. I hereby certify that I attended the deceased from 1995 to 1995, that I last saw him alive on 10/2/95 and that death occurred on the date and hour stated above.

Immediate cause of death cardiac arrest Duration

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)  
(b) Date of occurrence  
(c) Where did injury occur? (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

S-34897